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UNICEF/WHO JOINT COMMITTEE ON HEALTH POLICY

Report of the twenty-eighth session held at the headquarters of the World Health Organization

Geneva, 28-30 January 1991

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UNICEF-WHO JOINT COMMITTEE ON HEALTH POLICY JCHP28/91/21

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REPORT OF THE TWENTY-EIGHTH SESSION HELD AT THE HEADQUARTERS OF THE WORLD HEALTH ORGANIZATION

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I. INTRODUCTION

1. Dr Y. Kawaguchi, Director, Planning, Coordination and Cooperation, WHO opened the session and welcomed the participants. He called for nominations for Chairman and two Rapporteurs.

2. Dr S. Tapa (Tonga), member of the WHO Executive Board, was unanimously elected Chairman. Dr Audrey F. Manley (United States of America), member of the UNICEF Executive Board, and Dr E. Espinosa, member of the WHO Executive Board, were elected Rapporteurs.

3. The Chairman observed that the UNICEF/WHO Joint Committee on Health Policy (JCHP) was a shining example of the ability of two related organizations of the United Nations system to find effective and efficient ways of cooperating in order to support countries, particularly the developing countries, in their efforts to achieve their health and development goals within the context of health for all and primary health care. A share of the responsibility for effective coordination of technical cooperation activities in countries lay with the organizations of the United Nations system, and the JCHP, through which WHO and UNICEF had worked together for over 40 years, was well placed, at the start of a new decade, to ensure successful complementary action to that end by both secretariats.

4. In shouldering the responsibility to use the skills and resources that could be mustered to help families, especially poor families, and in particular women and children, to confront what were to many of them insurmountable difficulties, UNICEF and WHO were guided by the fundamental philosophy expressed in the Declaration of Alma-Ata, which affirmed that health for all could be achieved and that primary health care was the key to attaining that worldwide objective. With that in mind, the two organizations had developed many complementary strategies over the years. For example, the common goals for the health of women and children for the 1990s had been forged for some of which success was in sight while the remainder were capable of attainment. The recent World Summit for Children gave further hope that by the dawn of the twenty-first century the prospects for women and children alive in the 1990s and for those born at the start of the new century would have fundamentally improved.

5. The Chairman concluded by outlining the work of the Joint Committee. It would begin by reviewing basic policies and the follow-up actions that had been and would be taken to implement the common goals, and would prepare succinct and implementable recommendations to WHO and UNICEF for further action. The common goals had been endorsed by the World Summit for Children on 30 September 1990, and it was reasonable to expect that the heads of state and government who had pledged their support to the Summit's Declaration and the Plan of Action would come forward with the policies and economic support required to realize those goals.

6. Other pressing problems for the Committee's consideration included the approaches required to persuade young people to adopt healthy life-styles and the vulnerability of women and children to the scourge of AIDS, with the need to involve families and mothers in the fight against that disease. Progress reports would be considered and there would be preliminary discussion on how to provide more effective support to governments, particularly in developing countries, in instituting the type of health infrastructure that would render the peripheral health system more operational, more soundly oriented and therefore sustainable, within the countries' overall health system.

7. The proposed agenda was adopted with changes and is attached as Annex 1. The list of participants is given in Annex 2.

II. SUMMARY OF STATEMENTS BY THE DIRECTOR-GENERAL OF WHO AND THE EXECUTIVE DIRECTOR OF UNICEF

8. Dr Hiroshi Nakajima, Director-General of WHO, opened by referring to what was a unique and significant JCHP session, coming as it did after the World Summit for Children and the entry into force of the Convention on the Rights of the Child, but also shortly after the start of hostilities in the Gulf. Indeed, the session was taking place at a time of ever-increasing uncertainty and crisis, in a world economic situation marked by the debt crisis of the developing countries and the threat of recession, even depression, in the developed countries - at a time when, despite recent United Nations efforts, there had been no peace dividend.

9. Against such a background, the health and welfare of children were in danger and action must be taken to protect them. To that end, alliance among international organizations was all-important. Coordination and cooperation were much-used words within the United Nations system, but they must be made to take on even greater meaning so that international organizations could go forward hand in hand with their work. In that respect, the united action of WHO and UNICEF had been much improved at global level, in both policy and technical aspects. Policy coordination within the framework of the Child Survival Programme would, however, have to progress beyond expressions of commitment and take the form of concrete, follow-up action to the World Summit for Children, i.e., a child survival and development programme whereby children would have access to all they needed for their development.

10. Discussion of joint policy formulation was expected to become more unified, coherent and pragmatic in its implementation; piece-meal development of isolated programmes must give way to overall development to promote the health of women and children as part of the effort to achieve a peaceful world in the coming century. Such development must start at the birth of the child, and include reidentification of men's role in child development and family planning.

11. In that context, WHO was moving rapidly towards increasingly coherent, holistic action - towards a new health paradigm. At the most recent session of its Executive Board (14-25 January 1991), two main lines of interest had emerged: the first reflecting professional concern about health development, and the second focusing on sound health infrastructure and the determination of levels of priority. The time had come to merge individual programmes to form an infrastructure for child development and to build a solid framework for action.

12. JCHP had an important role to play in providing guidance for joint planning by UNICEF and WHO in order that the recommendations of the World Summit for Children might be implemented and the common goal of child development achieved. While some successes had already been recorded - the Expanded Programme on Immunization, for example - such development was still in its early stages and much remained to be done.

13. Mr James P. Grant, Executive Director of UNICEF, said that the JCHP was meeting at a time of great celebration in the long history of that unique body. The goals it had recommended at its session in 1989 had marked the beginning of a remarkable and historic two-year period for children. A consensus had emerged at that session on the establishment of an ambitious set of goals and strategies, built on the confidence that had arisen out of past experience and that had become particularly vigorous since the International Conference on Primary Health Care, held in Alma-Ata in 1978. Progress in health had been paralleled by the move forward in education following the World Conference on Education for All, held in Jomtien, Thailand, in March 1990. Successes in the health field in the 1980s had provided inspiration to heads of state to take action on behalf of children, leading to the ratification of the Convention on the Rights of the Child in under one year - a promptness unprecedented in the adoption of human rights instruments. In a parallel process, UNDP had issued its Human

Development Report in May 1990 and the World Bank's World Development Report of July 1990 had focused on attacking poverty, thus marking a shift away from measuring progress in terms of the growth of gross national product alone and towards the inclusion of social development indicators.

14. Agreement on the common goals for women and children set by UNICEF and WHO had meant that preparations for and discussions before and at the World Summit for Children had resulted in the emergence of those goals intact, thereby giving full significance to the Convention on the Rights of the Child. The subsequent acceptance by the United Nations General Assembly of the Summit's World Declaration on the Survival, Protection and Development of Children and of the Plan of Action had meant that United Nations agencies had been requested to take an active and united approach to implementing its recommendations.

15. The Summit provided the basis for an unprecedented opportunity and remarkable international commitment - 71 heads of state and government had themselves signed the Declaration and 81 others had authorized observer delegations to sign. In addition, the Convention provided the legal framework by which children had the right to such benefits as primary health care and access to clean water. Progress on behalf of children provided both the opportunity to move forward by implementing the stated goals and the means by which to establish a new pattern of cooperation, which might serve as a model, in environmental matters for example, in the years ahead.

16. The year to come was particularly important since people would be looking to see whether the World Summit had been mere rhetoric or whether it would be followed up by concrete action. Although the Gulf crisis might well have been taken as an excuse for inaction, heads of state had made it clear in September 1990 that they none the less intended to move forward.

III. REVIEW OF WHO HEALTH POLICIES AND UNICEF RESOLUTIONS

17. The policies before the Committee, as summarized in document JCHP28/91/2, were embodied in World Health Assembly resolutions and UNICEF Executive Board decisions adopted subsequent to the twenty-seventh session, in 1989. It was noted that a set of common themes runs through the Health Assembly resolutions; they include the need to reinforce the primary health care component and ensure its implementation; the need for financial management of scarce resources; the need for public information and the participation of people in solving their health problems; the need to give priority to technical cooperation and financial support to countries and peoples in greatest need and where the economic crisis has had the most serious effects; the need for intersectoral approaches to meet basic health needs; the need to develop an integrated approach to disease control; and the need to mobilize extrabudgetary financing to support high-priority programmes.

18. Discussion focused primarily on the set of Health Assembly resolutions related to implementation of health-for-all strategies through primary health care and the establishment of health care infrastructures to achieve health-for-all goals. WHO's major causes for concern are the increasing fragmentation of health care services, the absence of viable national health care systems in many countries, and the resulting difficulty of building up a sustainable system based on primary health care. In this context it is action in districts that is most needed as the means of accelerating the implementation of primary health care.

19. UNICEF JCHP members and the UNICEF secretariat stressed the operational nature of UNICEF and its attention to programmes that have the potential to "go to scale", i.e., to expand effective action as widely as possible where it will have the greatest impact; its emphasis on a decentralized structure, with particular emphasis on community involvement and special attention to the disadvantaged; its focus on mothers and children as compared to WHO's broad mandate in health; and its efforts to "do the doable" in the light of limited resources.

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20. The UNICEF secretariat noted that a key issue appears to be options appraisal - what different options are available to do a given job. UNICEF, for example, has initiated two regional programmes - one for the Special Adjustment Facility for Latin America and the Caribbean (SAFLAC) and the other for the Bamako Initiative for Africa - which were in direct response to the World Health Assembly policy guidance to give priority to technical cooperation and financial support to countries and peoples in greatest need and where the economic crisis has had the most serious effects. The UNICEF Executive Board has also reflected the various Health Assembly resolutions on health-for-all strategies and primary health care in its own decisions.

21. JCHP considered that it would be desirable to examine the possibility of linking established national health systems with the UNICEF focus on the community level - at which few financing bodies usually contribute - in an effort to strengthen the effectiveness of the two organizations' efforts, while encouraging each organization to deal with health issues according to its particular capabilities. Another major challenge is to assist community and government structures to interact in a mutually supportive way.

22. WHO/JCHP members strongly encouraged the bringing together, to a greater degree than is now the case, of UNICEF and WHO resources to help establish the foundations necessary to reduce morbidity and mortality through strengthened systems of health care - not just basic health care, but national health care systems that focus on the vital importance of districts. It was emphasized that further discussion is needed of how this might be done.

23. There was consensus on the importance of the primary health care approach. Primary health care, as defined at Alma-Ata, encompasses a range of activities that include essential drugs, immunization, water and sanitation. It provides a comprehensive framework, but it is the countries themselves that must play the key role through their own decision-making processes, putting together the parts into a larger whole with support from WHO.

24. It was noted that UNICEF has given priority to programmes that most directly and urgently have the potential to reach every village, while working with financing agencies to support the infrastructure costs for rural health centres and hospitals. It was further noted that the UNICEF Executive Board has encouraged UNICEF to capitalize basic health infrastructure.

25. Resolution WHA42.41, on the health of youth, was commented on favourably as providing an umbrella approach encompassing the abuse of tobacco, alcohol and other substances; preventable psychosocial difficulties; sexually transmitted diseases, including AIDS; early pregnancy; and other health problems. This provided guidance for operational programmes for the health of young people.

26. Recommendations

(1) JCHP took note of the resolutions and decisions reviewed in document JCHP28/91/2 and recommended their submission to the Executive Boards of UNICEF and WHO for the consideration or endorsement by each Board of the other organization's adopted texts.

(2) Resolution WHA42.41, on the health of youth, should be brought to the attention of the UNICEF Executive Board as an important umbrella for a range of operational activities in health communications related to the needs of youths.

(3) An informal working group should be established to consider how the two organizations can bring their respective strengths and experience to bear on reinforcing the primary health care infrastructure, and particularly the linkage between the district and community levels.

IV. WORLD SUMMIT FOR CHILDREN

27. The document for this item[1] was introduced with the comment that the World Summit for Children, the World Declaration on the Survival, Protection and Development of Children, and the related Plan of Action are particularly noteworthy because they go beyond an expression of general principle and include a set of quantitative goals for the year 2000. The Declaration sets forth a commitment for 1991 for nations to review their national plans and budgets as a step towards realizing the goals in industrialized and developing countries alike. Development financing agencies have committed themselves to examine their budgets in terms of their adequacy and support for the goals of the Summit.

28. The JCHP noted that the United Nations General Assembly, in resolution 45/217, of 21 December 1990, accepts the Declaration and requests the Secretary-General to report to the forty-seventh session in 1992 on implementation of the Plan of Action by the relevant United Nations agencies through the Economic and Social Council. This action, coupled with the signing of the Declaration by 71 heads of state or government and delegates from 81 other governments, represents an unprecedented degree of accountability. Moreover, agencies of the United Nations system are asked to report to their governing bodies by the end of 1991 on their action plans related to the Summit. In this context, it is urged that UNICEF and WHO should serve as role models within the United Nations system.

29. The JCHP agreed that the Declaration and the related Plan of Action are historic documents and that the achievement of their goals must be pursued vigorously. The Plan of Action provides an unique opportunity for collaboration and cooperation between UNICEF and WHO.

30. The indicators for measuring progress in implementing the Plan of Action and their relationship to health-for-all goals and indicators were discussed. WHO's 12 major indicators established in the context of health for all still form a nucleus for assessing the health status of populations. Official evaluations have been undertaken and the usefulness of indicators and means of refining them are constantly under consideration. They provide a useful base on which to build and to which additional indicators - for example, indicators of community participation - can be added. The main indicator, despite the fact that it is difficult to assess, remains political commitment; without that, little can be achieved. The World Summit for Children is one expression of such a commitment. However, the monitoring and evaluation process, in the context of the Summit's Plan of Action, requires further consultation to ensure that WHO and UNICEF synergistically make use of existing processes and mechanisms where possible. To that end a special session of the JCHP should be held in 1992, at which the principal emphasis would be on the follow-up to the Summit.

31. The JCHP noted that the WHO Executive Board at its eighty-seventh session (14-25 January 1991) recommended that an item on follow-up to the World Summit for Children be included on the agenda of the Forty-fourth World Health Assembly. This will provide an opportunity for the WHO divisions concerned to develop appropriate action plans and for WHO to intensify its own monitoring processes. This could be a supportive process for health for all, and, at the same time, could be specifically oriented toward the goals and objectives of the Summit.

32. Attention was drawn to the fact that some of the goals of the Summit are related to the mandates of other organizations such as UNFPA, UNESCO, and the World Bank.

33. Recommendations

(1) JCHP recommends to the World Health Assembly and to the Executive Boards of WHO and UNICEF that they:

(a) Endorse the World Declaration on the Survival, Protection and Development of Children and its related Plan of Action;

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[1] Document JCHP28/91/3.

(b) Direct their respective organizations to develop implementation plans for endorsement by their respective governing bodies before the end of 1991 to articulate the actions each agency will take in the coming decade to ensure the achievement of the goals enunciated in the Declaration and the Plan of Action and to monitor progress towards these goals;

(c) Request the secretariats of WHO and UNICEF to continue their collaboration and to intensify and accelerate the complementary planning of actions which the two agencies will undertake on a collaborative basis during the decade of the 1990s to ensure the achievement of the goals endorsed by the World Summit for Children and to monitor progress towards these goals.

(2) JCHP further recommends that a special session of the Committee be held in 1992, at which the principal emphasis would be on the follow-up to the World Summit for Children and on management of the peripheral health system based on primary health care.

V. WHO/UNICEF COMMON GOALS FOR THE HEALTH OF WOMEN AND CHILDREN - CHALLENGES FOR THE 1990s

34. Introducing this agenda item, the Chairman observed that UNICEF and WHO have reached the threshold of a new understanding and should take the unique opportunity to attain the WHO/UNICEF common goals for the health of women and children. The health of women and children forms a continuum from one generation to another; their health needs reflect not only their inherent vulnerabilities but also the social, ecological and historical situation of human societies. The implications for the health sector have become more apparent in the light of the experiences of countries in their efforts to apply the technologies and approaches that have emerged over the last 10-15 years. To be optimally effective and efficient, the various interventions and actions for maternal and child health must constitute a whole, with the various components linked and integrated. Such an approach is urgent since, just as the technologies are becoming available to countries, economic and social crises are threatening the capacity of countries to absorb them and to sustain their health care infrastructure. The economic plight of many developing countries is forcing a broad retreat in addressing social issues in general and health in particular.

35. The health of women and children is being threatened by imbalances in the distribution of and access to resources, by discrimination against women, by high rates of female illiteracy, and by rapid changes such as urbanization. The mobilization and collaboration of related social and economic sectors in support of the common goals is therefore a critical component of the proposed strategy.

36. Those common goals, endorsed by the World Summit for Children, reflect the view that the health sector has both the technical knowledge and the programme experience to be able to reduce overall maternal, infant and under-five mortality rates, as well as to eliminate the immediate and underlying causes of those deaths. What is needed is to apply what is known, while at the same time supporting research aimed at increasing the availability of effective means of intervention, such as vaccines. It is also necessary to focus on the interrelated determinants of women's health, including education, nutrition and family planning; these should be linked to actions for care of the newborn, breast-feeding, infant and young child nutrition, as well as disease prevention, protection and care.

Reduction of infant and child mortality

37. Reviewing this topic, the JCHP noted that thinking on how to reduce infant and child mortality[2] is in a state of continuous evolution as situations and technology change and that there are four major avenues along which action can be channelled. The first is to concentrate action on the major causes of death among infants and children under five in the seven major categories in which 80-90% of such deaths occur. In six of those

[2] Document JCHP28/91/5.

categories (vaccine-preventable diseases, diarrhoeal diseases, acute respiratory infections, malaria, low birth weight, and inadequate spacing of births) morbidity and mortality are controllable with the technology now available. In the seventh, AIDS, the only option at present is prevention. The second avenue is to concentrate action on areas where mortality is high. The third is to tackle the health-related factors that underlie high mortality, in particular nutrition and all aspects of malnutrition, basic education of women and mothers, income levels, water supply and sanitation, and the status of women. The fourth avenue is to apply improved methodology and technology. There is, in addition, an underlying need to ensure that a health care system is in place to respond to needs, that a monitoring system is in place to assess progress, and that efforts are being made to promote value systems in which preventable death is not acceptable and people and communities are empowered to cope with problems themselves or to know where to seek help. Implementation of all those activities will go a long way towards reducing infant and child mortality rates.

38. The Committee noted that reduction of infant and child mortality was interlinked with the next topic for its consideration - namely, women's health, safe motherhood and newborn care. In each of the six major disease categories where action has to be taken to reduce infant and child mortality, there is a complementary series of activities directed to meeting the needs of women during pregnancy and the perinatal period. That two-pronged approach, which will provide maximum impact on mother and child health in those six categories, is an example of the holistic approach now being taken in maternal and child health.

39. It was suggested that, in developing countries, first priority should be given to rural rather than urban communities, since the latter usually have greater access to services, though urban services should not be neglected. It is essential that a health care system with appropriate staff and technology should be available to population groups, be it a village or other settlement or group of settlements. Action on health-related factors in intersectoral efforts to reduce mortality, though sometimes difficult to implement, is nevertheless very important.

40. With regard to AIDS, UNICEF now has programmes operating in several African countries.[3] The policy in immunization programmes to promote the single use of needles and syringes should help to limit the spread of AIDS by this route, as well as the spread of hepatitis B. Where disposable instruments are not available, sterilization after each use of needle or syringe is being promoted.

41. The JCHP agreed upon the following conclusions:

(1) The goal of reducing the infant and under-five mortality rates by one-third or to 50 and 70 per 1000 live births, respectively, whichever is the lesser, between 1990 and the year 2000, is achievable with existing technologies and skills and by mobilizing the resources that could be made available. Nevertheless, this goal represents a major challenge operationally and politically.

(2) While the goals of the past decade focused largely on coverage and access to services, the health and nutrition goals for the 1990s are fundamentally impact goals. This demands substantially better management of maternal and child health status and better management of the systems that have an impact on that status at all levels. This further demands that national epidemiological capabilities be strengthened and that epidemiological principles and methodologies form a basis for the formulation of health policy, as well as for the design, management and evaluation of intervention programmes.

(3) To attain the infant and child mortality reduction goal requires that the health sector provides leadership, and vigorously seeks and forges strengthened operational linkages with the communications, education, water and agricultural sectors. Strengthening and sustaining the systems - formal and informal - required

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[3] See paragraph 121 below.

to reach this goal, will require further emphasis on social mobilization at all levels, focused on achievable targets, using simple and powerful health messages along with effective and affordable technologies.

(4) Lowered infant and child mortality is an indicator of overall well-being as well as a reflection of improvements in health. Achieving the infant and child mortality reduction goal requires, a priori, that other health and nutrition goals for the decade are substantially met. Reduction of mortality from acute respiratory infections and diarrhoea; reduction of mortality from vaccine-preventable diseases, and reduction of maternal mortality are all necessary prerequisites to achieving the paramount goal of reducing infant and child mortality. In addition, substantial progress will have to be made in controlling diseases such as malaria and AIDS, which are major contributors to infant and child deaths in certain parts of the world, and in improving technology in these areas.

Women's health, safe motherhood and newborn care

42. The JCHP appreciated that the topics dealt with in the document under review[4] represent a continuation of the efforts directed at reducing mortality among infants and children under five. Three points were emphasized. First, despite the focus on the link between women's health, safe motherhood and care of the newborn, it is important that women's health should be looked at in its own right and not merely as a contribution to child survival or to achieve a change in fertility patterns. Failure to recognize that point must have a negative impact on child survival and fertility, whereas recognition of and attention to women's health can make a positive contribution.

43. Second, it is important in the process of translating international instruments into action at national level that the Convention on the Rights of the Child, which came into force on 2 September 1990,[5] should be linked to the Convention on the Elimination of All Forms of Discrimination Against Women, adopted in 1979.[6] The provisions of those two conventions complement and reinforce each other and progress in maternal and child health will result from their implementation. Many problems of reproductive health suffered by women stem directly from the inequity in health care and nutrition that they suffered as children, requiring that a special emphasis be placed on the needs of the girl child and adolescent female.

44. Third, the three-tier system of primary health care at village level, access to a health centre, and the possibility of referral to a district hospital is essential to ensure that women with difficult pregnancies receive adequate care. Unfortunately, the central tier is weakening. This includes staff such as trained midwives and skilled personnel critical for safe motherhood; but supervision of and support to traditional birth attendants and health centres are deficient, skilled people are not being trained in sufficient numbers, and those in place are not having their skills updated. As a result, in some settings, despite recourse to antenatal and delivery care, women are dying at the same rate as those receiving no care at all. If maternal health goals are to be achieved, it is essential that the middle level of care should be restored, since appropriate technologies are available for application at that level, including the clean and atraumatic delivery strategy, which could save 60-80% of newborn infants. For the survival of the mother and for as many births as possible to result in an intellectually intact child, an effective system for safe motherhood and care of the newborn is required. It is therefore vitally important to review the situation of the nurse/midwife in order to use this valuable source of health manpower more efficiently and effectively.

45. The importance of using risk factors at community level to guide health planning and interventions was stressed. This should provide direction for building up community

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[4] Document JCHP28/91/6 Rev. 1.

[5] United Nations General Assembly resolution 45/104, 14 December 1990.

[6] United Nations General Assembly resolution 34/180, 18 December 1979.

services within primary health care in order that mothers can be referred to a level at which they can be treated, and that communities at greater risk can receive increased resources and attention.

46. The JCHP was informed that a recent WHO publication entitled Integrating Maternal and Child Health Services with Primary Health Care[7] illustrates how any health programme, including one for safe motherhood, can be made an entry-point for primary health care, provided that this has been planned at the outset. WHO was concerned that, although the Alma-Ata Conference has inspired a great effort to introduce community health care, some countries are now abandoning the community health worker approach because such workers lack middle-level support. The term "district health system", as understood by WHO, comprises action at community level, supported by health centres and the first-referral hospital. A WHO Study Group on the Functions of Hospitals at the First Referral Level has recently considered the role of the first-referral hospital in primary health care; its report[8] regrets that no funding agencies appear to be willing to support such hospitals.

47. It was noted that UNICEF has supported the training and equipping of traditional birth attendants and related activities for two decades, and in April 1990, the UNICEF Executive Board approved a policy outlining a more comprehensive strategy for safe motherhood. UNICEF has collaborated closely in this field with WHO as well as with UNFPA, the World Bank, UNDP and several nongovernmental organizations. A working group has been set up to formulate a plan of action for future joint efforts; the plan is expected to be ready by mid-1991.

48. The JCHP welcomed document JCHP28/91/6 Rev.1, which stressed the complementary roles of WHO and UNICEF in furthering safe motherhood. It was suggested, however, that in view of the complexity of the problem posed by less than adequate family planning, the JCHP should make a clear recommendation in favour of strengthened collaboration between all the international agencies concerned, in particular the IPPF and the World Bank. Such a recommendation would also be in line with the spirit of the World Summit for Children. With regard to the use of contraceptives, it was noted that in some areas in Africa a very low percentage of available contraceptives is being used and that improvement of supply is not the only answer. A deeper inquiry may be needed and a collective effort made to promote acceptance of the need for child spacing by the population in order to ensure that use is made of available information and services.

49. The JCHP recognized that women's health, safe motherhood and care of the newborn are central to WHO and UNICEF collaboration in the effort to halve the worldwide maternal mortality rate by the year 2000 and the complementary effort to cut mortality among infants and children under five to 50% and 70%, respectively, during the 1990s. In that respect, many countries are in a stage of transition, in that further significant reduction in those mortality rates can be achieved only by greater attention to the neonatal period.

50. Another important aspect is the need to deal with the underlying causes of medical problems. They relate to development, women's status, education, etc. In coping with those aspects, UNICEF and WHO need to rely on collaboration with other international organizations. It is also essential to work with national structures and enhance their capabilities. That should be the real focus of all efforts.

51. It was also noted that the deterioration in many national health services results from the heavy debt burden borne by the countries involved. Organizations such as the World Bank and the Inter-American Development Bank could provide help by taking action to relieve the debt burden.

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[7] Hart, R.H. et al. Integrating maternal and child health services with primary health care: practical considerations, Geneva, World Health Organization, 1990.

[8] Report in preparation. See also WHO Technical Report Series, No. 744, 1987 (Hospitals and health for all: report of a WHO Expert Committee on the Role of Hospitals at the First Referral Level).

52. There was consensus that the long-term aim of improving maternal health is to improve the quality of life and thus that of future generations. Such improvement depends, inter alia, on access to health services that are within the socioeconomic reach of the population. Provision of district hospitals is not enough; access to them has to be ensured by making them affordable to the people in need of their services and by ensuring that they are effective in dealing with the people's problems. One aspect of this problem is being addressed by the Bamako Initiative, which seeks to make essential drugs available at village level at prices the population can afford.

53. Recommendations

(1) The JCHP is concerned that women's health issues have received scant attention both internationally and nationally and recommends that they now receive more attention from WHO and UNICEF.

(2) The JCHP recommends that WHO and UNICEF work together with UNFPA and other relevant agencies to strengthen the integration of family planning with other components of maternal and child health.

(3) The JCHP further recommends that WHO and UNICEF, in close cooperation with national authorities, develop an integrated strategy for the health of women and children, bearing in mind that action should be oriented towards both the community and the first referral level. Promotion of simple, inexpensive technologies, district-oriented training and management, and community participation in maternal care and care of the newborn must also be considered, and a report should be made to the recommended special session of the JCHP in 1992 in connection with the management of the peripheral health system.[9]

Promotive and preventive actions

54. Expanded Programme on Immunization (EPI). The Committee's review of EPI was based on a report[10] on the achievements of the programme and the challenges for the 1990s. EPI was characterized as a shining example of UNICEF and WHO cooperation. Nevertheless, an estimated 2.6 million children die every year from vaccine-preventable diseases. Attention was drawn to the excellent interchange of personnel between UNICEF and WHO. The new Vaccine Independence Initiative, created to make EPI more sustainable by giving certain countries greater self-reliance in their immunization programmes, was noted. The Committee also noted the specific agreed goals on reduction of measles, eradication of poliomyelitis, elimination of neonatal tetanus, and achieving 90% immunization coverage by the year 2000. It was noted that better surveillance is needed to direct resources to areas of greatest need. The possibility of using the 500 million contacts for immunization purposes to enhance other primary health care components pertinent to children and mothers was stressed.

55. The Children's Vaccine Initiative was discussed. A component of this initiative would include strengthening of national epidemiological capacities in addition to vaccine research to develop new or improved vaccines for children. In its discussion, the JCHP stressed the need for continued efforts to ensure sustainability of the achievements and continuity of programme activities through development and improvement of adequate infrastructure and training of health workers at all levels, including the district and the village. The importance of continuing and refining community and social mobilization to reduce drop-out rates was discussed.

56. Recommendations. The JCHP recommends that WHO and UNICEF continue their partnership in supporting all countries, in accordance with their needs and priorities, to reach the global EPI goals, paying adequate attention to the mobilization and empowerment of the

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[9] See paragraphs 33(2) and 133(2).

[10] Document JCHP28/91/7.

community. In so doing, adequate attention should also be given to the establishment of infrastructures that will ensure sustainability and strengthening of primary health care in general. JCHP also recommends that both organizations give full support to the Children's Vaccine Initiative.

57. Diarrhoeal diseases control (CDD). The extent of the problem[11] and the progress of the global CDD programme were briefly summarized. A slowing of progress has been noted in the last years of the 1980s, and renewed commitment is needed.

58. WHO and UNICEF enjoy excellent collaboration in this area. Joint strategies for the 1990s are backed up by a wide range of technical guidelines, training materials and other tools for programme implementation.

59. The JCHP noted that the main strategies are:

(a) Correct management of diarrhoea cases in the home and in health facilities. All episodes should receive continued feeding with nutrient-rich food and increased fluids. Access to oral rehydration salts has to be assured for the cases who need it. The use of drugs should be selective and limited. Decreasing recourse to useless and potentially harmful drugs is also important. This strategy should be implemented by training of health staff and strengthening of health services, particularly at the middle levels, and by effective communication with the community.

(b) Promotion of feasible preventive interventions, including measles immunization, promotion of breast-feeding (particularly exclusive breast-feeding in the first 4-6 months of life), and inclusion of appropriate health education in all water supply and sanitation projects.

60. The JCHP stressed that in order to achieve the targets proposed for diarrhoeal disease control in document JCHP28/91/8 and the goal of reducing diarrhoea mortality by one half by the year 2000 it will be necessary to involve the community and promote a sense of responsibility for prevention of unnecessary deaths.

61. JCHP members further stressed the importance of feeding (and of nutrition in general) in diarrhoeal disease control, the need to ensure access to adequate water supplies, and the need to ensure adequate production of oral rehydration salts in all regions.

62. Recommendation. The JCHP recommends the following targets and goals and urges WHO and UNICEF to take all necessary joint measures to ensure that they are realized:

Targets

	Status end 1989	1995 target	2000 target
General programme targets			
Supervisory skills training coverage	17%	40%	60%
Correct case management strategy			
ORS access rate	58%	80%	95%
Case management rate		50%	75%
Case management training coverage	11%	40%	75%
Diarrhoea preventive strategies			
Breast-feeding rates	Indicators and targets to be defined		
Measles immunization	As defined by EPI		

[11] Document JCHP28/91/8.

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Goals (impact targets)

Achievement of the above targets is expected to result in the following reductions compared with 1990 levels:

	by 1995	by 2000
Diarrhoea deaths in children under five years	25%	50%
Diarrhoea incidence in children under five years	10%	25%

63. Acute respiratory infections (ARI). The JCHP was informed that acute respiratory infections (ARI)[12] are the largest single cause of childhood mortality, estimated to have accounted for 4 million deaths in children less than five years old in 1990.

64. Twenty-five percent of ARI deaths may be preventable by currently used vaccines. The majority are preventable by improved case management and reduction of risk factors. The common management of the ARI and CDD programmes within WHO was briefly explained.

65. UNICEF and WHO believe there is sufficient evidence to show that a simplified protocol for detection and treatment of pneumonia can be taught to and used by peripheral health workers. A range of training materials is under development.

66. The major emphasis in the coming years should be to work with countries to develop national policies, guidelines and plans to assist with programme implementation, particularly training of health staff. The success of the ARI programme will depend heavily on the health services, and improving treatment at first- and second-level referral facilities is the priority in the first stage of a phased approach to national programme development. It will also be important to collaborate with essential drugs programmes to ensure an adequate supply of antibiotics at the periphery for use in treating childhood pneumonia.

67. The JCHP was informed that a number of research issues, notably clinical and behavioural aspects of case management, are already being addressed. Potential strategies are also under review.

68. Excellent collaboration between UNICEF and WHO prevails and will be critical in scaling up ARI control efforts in order to achieve the goal, endorsed by the World Summit for Children, of a one-third reduction in ARI-associated mortality by the year 2000. Elimination of risk factors for severe ARI implies a number of coordinated primary health care interventions - for example, those aimed at malnutrition and low birth weight and at childhood immunization.

69. JCHP members commented on the need to make it clear that the ARI programme primarily targeted pneumonia and not the highly prevalent mild manifestations of acute respiratory infections, about which little could be done. They also expressed concern at the current polypharmacy treatment of ARI.

70. Recommendation. The JCHP recommends that activities to achieve the following targets and goals be vigorously pursued:

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[12] Document JCHP28/91/9.

Targets

	Status end 1989	1995 target	2000 target
General programme targets			
Target countries with operational ARI control programmes*	25%	95%	95%
Correct case management strategy			
Facility-based staff trained in ARI case management		5%	15%
ARI standard case management access rate	15%	50%	75%
Childhood pneumonia cases treated with recommended antibiotics	12%	40%	60%

*Target countries are currently defined as those having an infant mortality rate greater than 40 per 1000 live births per year. This definition may be reconsidered as progress is made in these countries.

Goals (Impact targets)

Achievement of the above targets is expected to result in the following reductions compared with 1990 levels:

	by 1995	by 2000
ARI deaths in children under five years	20%	33%

71. Nutrition. In considering the background document,[13] the JCHP noted that nutrition has a clear connection with other programmes under review by the Committee. Malnutrition arising from poverty leads to high infant mortality in many countries; it is also the cause of early death in many adults. Marginalized population groups within every country tend to have nutrition problems, and even the massive programmes useful in the past are likely to have limited impact today. Each country must take the lead in dealing with its specific problem. WHO can then play a catalytic role in supporting efforts at national level to attain the targets set. All WHO goals and strategies are derived from collective decisions taken by the Health Assembly and are expressed in the Seventh and Eighth General Programmes of Work and in specific resolutions of the Health Assembly.

72. UNICEF makes use of three different approaches in its efforts to help reduce malnutrition: first, the elimination of micronutrient deficiencies, using existing infrastructures; second, in areas with high malnutrition rates, the so-called "triple A" approach - namely, assessment, analysis and action; third, attention to patterns of child care, since in many countries it is not lack of food, but lack of knowledge, that is the chief problem.

73. The JCHP emphasized that breast-feeding (see paragraphs 81-85) is essential. Recent studies indicate that the downturn in the rate of breast-feeding in the industrialized world has not been halted, as has been thought. That downturn appears to be widespread and needs to be arrested. It was noted that the aims and principles of the International Code of Marketing of Breast-Milk Substitutes need to be included in national programmes.

74. If nutrition targets are to be attained, UNICEF and WHO will need to work in close collaboration with many other agencies with related interests. In view of the close relationship between nutrition and, for example, diarrhoeal diseases and cardiovascular

[13] Document JCHP28/91/10.

diseases, it is crucial that nutrition targets be included in all related health programmes.

75. There was consensus that improving nutrition remains among the most challenging tasks for the last decade of the twentieth century. Knowledge and skills are available to overcome the problem; the two agencies should therefore consider how the problem can be addressed more effectively than in the past. Nutrition is a vital factor in child survival. Nutritional surveillance should therefore be intensified and there should be feedback through all levels of health care. Successful community-based action to improve nutrition could perhaps be replicated in other countries. Priority should be accorded to the prevention of malnutrition through the use of anthropometry. Target groups include households, health services, and maternal care facilities. Experience has shown that maternal care makes an enormous contribution to the biological and psychological development of the child.

76. The JCHP noted that some countries have improved their nutritional well-being as a consequence of the approach they have adopted to development. While undernutrition is a disease of poverty, malnutrition often occurs in industrialized countries. In both cases, life expectancy is reduced.

77. Concern was expressed that achievements will remain limited so long as nutrition is considered simply a health problem. Nutrition was recognized by the Committee as a multidisciplinary area that would benefit from continuing interagency collaboration.

78. It was recommended that development planners be encouraged to use nutritional status as an indispensable indicator of development. Moreover, by linking nutrition with all related economic and social sectors, every United Nations organ or agency would be concerned in addressing the problem. The ACC Sub-Committee on Nutrition coordinates the efforts of the various United Nations agencies, while the goals for human development set out in the new International Development Strategy include six nutritional goals.

79. The Committee agreed that nutritional status is also an overarching indicator of quality of life and stressed the importance of nutritional surveillance of populations, especially vulnerable groups, and of community information systems to serve as a basis for timely interventions and for national nutrition policy and strategy. The Committee noted that economic indicators at the national level are more systematically collected than direct human development indicators such as nutritional status.

80. Recommendations. (1) The JCHP endorses the nutritional precepts set out in the annex to document JCHP28/91/10 and reproduced below:

(a) Measures to attack poverty and reduce inequity go to the root of the problem of hunger but much can be done to improve the nutrition of children under two years of age by strengthening the "caring capacity" of mothers - their knowledge and understanding and ability to apply these - for example, through contriving to reduce the burden on their time and energy.

(b) The growth of children is the outcome of a series of processes that ultimately influence household food security and health security, and the caring capacity of mothers and other members of the family. All three are necessary for good growth (or good nutritional status) but none is sufficient by itself.

(c) The most critical period is the first two years of life, when the growth pattern for the future is set.

(d) Improved nutrition of women is important for their own health and for that of their children.

(e) Exclusive breast-feeding is especially important not only for optimum nutrition of the child but also for protection from the frequency and severity of infection and for delaying conception.

(f) While breast-feeding should continue as long as possible, additional food must be introduced from the age of four to six months, with special attention paid to the frequency of feeding.

(g) Families must have access to sufficient and appropriate food to satisfy the needs of all their members throughout the different seasons of the year (i.e., be food secure). For many, this will mean adequate purchasing power, especially important for women; for some, it will mean direct involvement in food production for themselves.

(h) Community level action (supported as appropriate from outside), stemming from community involvement in assessment and analysis of the situation, is often the most effective way of mobilizing human and other resources for sustained economic and social development leading to improved nutrition.

(i) Access to credit and technical resources is frequently denied the poor, especially women, inhibiting initiative and self-help.

(j) Deficiency of vitamin A can lead not only to blindness but also to markedly increased mortality from infectious disease. Emphasis should be on improving dietary intake, but periodic supplementation with high doses of vitamin A to children below six years of age can be useful. Because of greater vulnerability to infection in the early years, it is sensible to ensure good liver stores during infancy. The great success of immunization programmes in reaching out to children in the first year of life provides a new opportunity to reach children also with vitamin A.

(k) Iodine deficiency is the single most important cause of mental deficiency as well as a cause of infant death, stunted growth, and poor physical performance. The addition of iodine to salt is the traditional way of attacking the problem, of proven effectiveness. Newer methods that have been shown to be effective are the addition of iodine to water supplies and the provision of iodized oil by mouth once in two years - especially important for pregnant women and young children to prevent cretinism.

(l) Iron deficiency is widespread throughout the world and is especially serious for pregnant women. A course of iron tablets daily throughout the second half of pregnancy can cost only 25 US cents.

(2) The JCHP recommends that UNICEF's experience and special concerns in nutrition should be adequately utilized in the preparations for the forthcoming WHO/FAO international conference on nutrition.

(3) The JCHP also recommends that nutritional status should be used as an indicator of the level of national development.

81. Breast-feeding. The JCHP noted that collaboration between WHO and UNICEF on breast-feeding dates back to before the Joint WHO/UNICEF Meeting on Infant and Young Child Feeding, held in 1979. The programme covers many areas, including diarrhoeal diseases, maternal and child health and nutrition, and the activities carried out by WHO and UNICEF are complementary. Attention was drawn to the proposed follow-up actions for WHO and UNICEF set out in the background document,[14] as well as to the Innocenti Declaration on the Protection, Promotion and Support of Breast-feeding,[15] which sets operational targets for governments to achieve by the year 1995 and calls upon international organizations to undertake support and promotional activities.

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[14] Document JCHP28/91/11.

[15] Adopted by participants at the WHO/UNICEF policymakers' meeting on "Breast-feeding in the 1990s: A global initiative", Spedale degli Innocenti, Florence, Italy, 1 August 1990.

82. The Innocenti Declaration provides a succinct summary of four recommended national actions as well as of appropriate international action. Inter alia, attention should be paid to both the social and health aspects of breast-feeding; health workers should be appropriately trained and social support to women should be ensured by enacting legislation and providing the necessary facilities. While the last-mentioned measures could, in theory, cover the formal work sector, the problem of facilitating breast-feeding for women in the informal sector remains to be solved. Because of the wide diversity between countries, strategies must be adapted to individual social contexts. Countries should be encouraged to give effect to the aims and principles of the International Code of Marketing of Breast-milk Substitutes; to that end, use should be made of experience in countries where the Code has been implemented.

83. The resistance on the part of health professionals to breast-feeding, because of its inconvenience to them, was noted; the Committee considered that its importance should not be underestimated.

84. Concern was expressed about the decline of breast-feeding, especially in consequence of the effective promotion of breast-milk substitutes. The Innocenti Declaration rightly recognizes that breast-feeding contributes to child spacing, and it supports women's right to breast-feed and thereby the child's right to be breast-fed. Many countries have already taken steps to curb the promotion of breast-milk substitutes and to protect and promote breast-feeding. Facilities should be provided to enable working women to continue breast-feeding.

85. Recommendations. (1) The JCHP recommends that changes and improvement in health care practices and procedures should be supported so that they correspond to the recommendations of the Joint WHO/UNICEF Statement on Protecting, Promoting and Supporting Breast-feeding.[16] By 1995 the Ten Steps to Successful Breast-feeding contained therein should be promoted within health care facilities and institutions, and the check-list on health care practices annexed to the Statement should be adapted and applied as an evaluation instrument and indicator of improvements.

(2) The JCHP also recommends that education and training of all health workers concerned with maternal and child health, including family planning, should be supported in order to provide them with an understanding of the importance of breast-feeding for the health of the mother and child. In-depth training in breast-feeding and lactation management should be organized in all regions and countries. The implementation of these education and training activities will necessitate the development of appropriate learning materials, revision of curricula and textbooks for different levels of health workers to promote and support breast-feeding, and the promotion of and support to centres for specialized training in breast-feeding and lactation management.

(3) The JCHP further recommends that WHO and UNICEF should:

(a) Promote and advocate legislative, regulatory and other actions that enable and facilitate exclusive and prolonged breast-feeding among working women, including the extension and enforcement of maternity leave.

(b) Provide continued technical support and encouragement to national action to give effect to the aim and principles of the International Code of Marketing of Breast-milk Substitutes, encourage and facilitate the exchange of national experiences in giving effect to the Code and subsequent relevant resolutions of the World Health Assembly in their entirety to facilitate reporting by national authorities on actions taken in their countries.

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16 Protecting, promoting and supporting breast-feeding: the special role of maternity services. A joint WHO/UNICEF statement, Geneva, World Health Organization, 1989.

(c) Promote, support and collaborate with national authorities in the development of communications strategies, approaches and materials for information dissemination on and motivation for breast-feeding, adapted to the local social and cultural setting, targeted to specific audiences, and directed at locally relevant problems.

(d) Encourage and support the involvement of nongovernmental organizations in promotion and support of breast-feeding, particularly of mothers' support groups, including their collaboration with the health sector.

(e) Promote and support operational research and policy analysis that would enable and facilitate all women to effect the infant feeding ideal,[17] and to encourage and promote a dialogue and partnership with government and among all interested parties to ensure that this ideal is not undermined.

(f) Ensure integration of breast-feeding promotion in all programmes supported by WHO and UNICEF.

(g) Continue advocacy and collaboration with other United Nations and bilateral agencies to protect and support the common goal for breast-feeding.

86. Water supply and sanitation. The JCHP recalled that the end of 1990 marked the end of the International Water and Sanitation Decade. It is estimated[18] that in 1990 over 1200 million people in developing countries were without access to safe water supply and over 1700 million had no access to appropriate sanitation, representing 31% of the population in developing countries without safe water supply and 43% without sanitation. There is a need to expand coverage of water supply and sanitation facilities to the populations now unserved or underserved, and efforts must be accelerated to implement the water supply and sanitation programme in order to enhance coverage. Nevertheless, coverage alone is not enough; the facilities must function and be used.

87. The JCHP emphasized that safe water and basic sanitation are essential elements of primary health care. Poor environmental sanitation, especially through unsafe water supplies, lack of sanitary means for the disposal of human wastes, and poor household hygiene are major contributors to both morbidity and mortality from diarrhoeal diseases. Studies have shown that reductions in diarrhoeal morbidity rates up to 40% can be achieved through improvements in both water quality and availability.[19] Other diseases that are positively affected by water supply and sanitation improvements include cholera, typhoid fever, amoebiasis, giardiasis and various helminthic diseases. Dracunculiasis (guinea-worm disease) can be controlled directly through safe and protected water supplies.

88. Other benefits of water supply and sanitation improvement would be reductions in time and effort devoted to water-carrying, effective entry-points for community involvement in development, and the economic benefits of household-level irrigation, animal husbandry and commercial activities.

89. The JCHP was informed that WHO and UNICEF have begun a joint programme to monitor key indicators of water supply and sanitation status at the country level, relating to coverage, utilization and financial support. The information will be used as a

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[17] Set out as follows in the Innocenti Declaration: "... all women should be enabled to practise exclusive breast-feeding and all infants should be fed exclusively on breast milk from birth to 4-6 months of age. Thereafter, children should continue to be breast-fed, while receiving appropriate and adequate complementary foods, for up to two years of age or beyond".

[18] Document JCHP28/91/12.

[19] Esrey, S.A., et al. Bulletin of the World Health Organization, 63: 757-772 (1985).

management tool by countries in their own water supply and sanitation programmes. WHO is providing an operations secretariat for computer software and data processing, while UNICEF is providing a programme secretariat for coordination of field activities. For the future, it is proposed, first, to maximize the health impact of water supply and sanitation through the establishment of stronger linkages between water supply and sanitation programmes and programmes to control water-related diseases (diarrhoea, dracunculiasis, schistosomiasis, and so forth), and through the establishment of community-based vector control groups; second, to strengthen the hygiene education components of water supply and sanitation through school programmes on hygiene education, curriculum development and school water supply and sanitation facilities, and through community programmes of health/hygiene education for adults and out-of-school youth; and third, to promote community-oriented programmes for water supply and sanitation, with emphasis on the role of women in the planning and management of water supply and sanitation activities. These are promising areas for joint activities between WHO and UNICEF. The task now will be to stimulate the desire and the will to implement action.

90. The JCHP noted that a major challenge now confronting the two organizations is how to accelerate coverage in a sustainable manner. The implementation rate of the 1980s must be increased by about 2.5 times during the 1990s to obtain universal coverage by the end of the century. The question is how that can be done. High on the list of approaches are management, mobilization and money.

91. It was agreed that monitoring should be used as a management tool, in order to apprise management regularly of the performance of the sector, not only at the national, but also at the subnational level. Mobilization for promotion and action will apply not only to communities for the management and maintenance of those facilities, but also to governments to create the climate for progress and to external support agencies to promote low-cost approaches. Of the total funds flowing into the sector, external support agencies - United Nations, bilateral, nongovernmental and so forth - contribute approximately 35%. Of that amount only 4% is assigned to low-cost approaches, and most of the resources are devoted to high-cost urban-type facilities. One study has shown that about US$ 36 billion a year would be needed to provide universal access by the year 2000, but one-third of that amount could provide 80% coverage by focusing on rural and low-income urban areas and using low-cost approaches.

92. It was therefore suggested that priorities be changed and that a larger proportion of expenditure be devoted to providing low-cost water supply and sanitation services for the unserved and underserved populations in both rural and urban-fringe areas. The responsibility of governments to ensure a basic infrastructure for water supply and sanitation was emphasized.

93. The JCHP emphasized that sanitation and hygiene are lagging behind water supply and need to be boosted. It is now known that it is not so much technical as social factors that need to be mobilized in order to get action. It is therefore necessary to focus more on the institutional aspects overlooked in the past and on the linkages with other programmes, such as those for diarrhoeal diseases control, nutrition (in connection with the energy expended by women on carrying water), and health education.

94. These approaches and strategies need to be operationalized. All the major actors should be involved in the achievement of the goal of water and sanitation for all, especially UNDP and the World Bank. Efforts must be made to influence their actions positively so that, if each follows its individual path within the sector, all will be directed towards a common end. That is the essence of complementarity of action.

95. Attention was drawn to the need to ensure operational maintenance, in particular to avoid the breakdown of pumps attached to boreholes, and to pay particular attention to waste disposal in order to prevent the contamination of water supplies. Concern was expressed about inadequate attention to the health impact of water supply and sanitation, because those who are responsible for these systems are often not responsible for health. Concern was also expressed that, despite the large amounts spent for water and sanitation, the health impact has not been well documented. Recent studies have shown the positive effect on children's health of the provision of water supply and sanitation.

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96. A potentially expanded role for the private sector was discussed, but the Committee noted the possible dangers of leaving such vital services to the private sector, where the profit motive might deprive poorer consumers of their essential needs. The need to monitor water supplies to ensure that health risks were avoided was stressed.

97. The linkage between the WHO and UNICEF programmes on water supply and sanitation and the United Nations Conference on Environment and Development, to be held in Brazil in June 1992, was discussed. This conference will emphasize ways and means of overcoming the negative consequences of socioeconomic development, including environmental pollution. It is important to ensure that the conference also addresses the consequences for human health of a lack of socioeconomic development and the related lack of potable water and adequate sanitation. Environmental health issues, including water supply and sanitation, as well as areas such as food safety, will be covered by WHO's Commission on Health and Environment. The report of the Commission will constitute WHO's major contribution to the United Nations conference. A joint WHO/UNICEF statement could be made on the negative impact of lack of socioeconomic development and related water and sanitation issues.

98. Recommendations. (1) The following areas were identified as being of particular importance and appropriate to WHO/UNICEF collaboration:

- ensuring the sustainability of water supply and sanitation systems by providing adequate operation and maintenance support;

- ensuring the development of new programmes targeting the poor and the unserved and underserved populations;

- applying new methodologies to promote the greater health impact of water supply and sanitation programmes, bearing in mind the difficulty of eliminating the confounding factors.

(2) The JCHP recommends the following activities:

(a) Maximizing the health impact of water and sanitation interventions through:

(i) establishment of stronger linkages between water and sanitation programmes and efforts to control water-related diseases (e.g., diarrhoea, dracunculiasis, schistosomiasis); and

(ii) preparation of community-based vector control programmes.

(b) strengthening hygiene-related components of water and sanitation interventions through:

(i) school programmes that combine hygiene education, curriculum development and the provision of proper water supply and sanitation facilities;

(ii) community programmes on health/hygiene education for adults and out-of-school children; and

(iii) promoting community-oriented programmes, with special emphasis on the role of women, with a view toward their full involvement in the planning and management of water supply and sanitation activities.

(c) Emphasizing the role of operation and maintenance as a means of improving the sustainability of water and sanitation facilities.

(d) Promoting poverty alleviation and focus on the poor by giving priority to the unserved and underserved populations in programme development.

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(e) Assessing the impact of water supply and sanitation on water-related diseases.

(3) The JCHP requested WHO and UNICEF to report to the next regular session of the Committee on the progress made in assessing the impact of water supply and sanitation on water-related diseases.

99. Dracunculiasis (guinea-worm disease). The JCHP was informed that dracunculiasis was formerly widespread in Africa, the southern part of Eurasia and in the New World, but is now confined to sub-Saharan Africa and the Indian subcontinent, where it affects 5-10 million people.[20] The two Asian countries affected are India and Pakistan, and both countries are on the point of attaining the goal of eradication. The problem in Africa is more difficult, with 16 countries affected to varying degrees. Two countries are, however, ahead in the advance towards elimination: Ghana and Nigeria (which had conducted its first case-search survey at the federal level in 1988).

100. The initial stages of the strategy that will lead to the elimination of dracunculiasis are now well codified, the first stage being an active case-search in order to draw up a very accurate epidemiological map of endemic villages and hamlets, and the second stage being the establishment of a national plan of action that takes account of the particular socioeconomic, cultural and ecological characteristics of the affected areas. In 1990, UNICEF played a major role in conducting case-search surveys.

101. Both organizations have engaged full-time personnel to work on this programme and there is excellent coordination between the two organizations. Both organizations also cooperate with the WHO Collaborating Centre for Training, Research and Eradication of Dracunculiasis, at the Centers for Disease Control, Atlanta, GA, USA, and with Global 2000, a non-profit entity of the Carter Presidential Center, also in Atlanta as well as with other international bilateral and nongovernmental agencies. The role of WHO is to help countries to draw up their national plans of action, to support elimination activities by sending experts and material aid. Another important role of WHO is to certify the elimination of dracunculiasis, country by country, ending with worldwide eradication.[21]

102. The year 1991 will be a turning-point in the history of the eradication of dracunculiasis, since there is now collective awareness of the problem and political figures at the highest level have committed themselves to support their national elimination programmes. This has been demonstrated by recommendation (in resolution EB87.R4) of the WHO Executive Board in January 1991 to the Forty-fourth World Health Assembly that it adopt a resolution on the eradication of the disease, which contains two essential paragraphs:

> "2. DECLARES its commitment to the goal of eradicating dracunculiasis during the 1990s, this being technically feasible given appropriate political, social and economic support;
>
> ...
>
> 6. URGES the Director-General:
>
> (1) to support global efforts to eradicate dracunculiasis during the 1990s particularly by the certification by WHO of the elimination of the disease country by country;

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[20] Document JCHP28/91/13.

[21] The minutes of a WHO informal consultation on the elimination of dracunculiasis, held in Geneva in February 1990, have been issued as document WHO/FIL/90.185.

(2) to support Member States in surveillance, programme development and implementation;

(3) to continue to seek extrabudgetary resources for this purpose;

(4) to keep the Executive Board and the Health Assembly informed of progress."

103. The Committee recognized that the disease is most prevalent in the most remote and poorest areas in 16 sub-Saharan African countries. Moreover, the cost of every case identified will rise exponentially as the goal of elimination nears, and there is a danger that the interest of national ministries of health and external donor agencies may at the same time decrease. This needs to be guarded against.

104. The key operational challenges that remain are: how to identify the most remote villages and link them to the primary health care system; how to maintain a sensitive but low-cost surveillance system over periods exceeding five or more years; how to communicate effectively the appropriate health education messages; and how to persuade individuals to change their water-use behaviour.

105. The JCHP was informed that initial national surveys to define programme areas have either been completed, are under way, or are about to begin in countries and reach or will reach over 80% of suspected endemic areas. Repeat national surveys, however, are not a substitute for establishing a community-based surveillance system. UNICEF also supports water-supply programmes in the countries with the highest endemicity, health education and community surveillance, an operational research network of health service, and research institutions to help address practical health communications and surveillance problems; it has also identified a successful and simple surgical extraction technique developed in India.

106. Certification of elimination, country by country, will require three years of active surveillance, with an adequate system, following a last-case report. Several countries are now ready, or nearly ready, to begin the process. Substantial technical and financial resources will have to be invested in this area in the near future.

107. Recommendation. The JCHP recommends further WHO/UNICEF collaboration in the following areas:

(a) Community surveillance methodologies. At the core of both the elimination and verification strategy is the requirement for low-cost, community-based disease surveillance. Further work will be required to develop and evaluate alternative approaches to this problem.

(b) Vector control strategies. Temephos kills the intermediate host of the dracunculiasis larvae and provides a safe and effective chemical treatment for ponds and other water sources. Further evaluation and monitoring will be required to optimize local strategies for its efficient use.

(c) Case-containment strategies. As countries near the elimination goal, the unit cost per case prevented rises substantially just as interest in dracunculiasis as a public health problem tends to decline significantly. Effective case-containment strategies will need to be developed to reduce this unit cost and minimize the time required for a country to move from very low endemicity to elimination.

(d) Mapping of remote villages. A problem common to the dracunculiasis elimination programme and other disease control programmes in the endemic areas (such as EPI and ivermectin distribution to control onchocerciasis) is that a very large number of small villages and hamlets do not appear on any map. New technologies offer much promise in this area and will need to be further explored and applied.

(e) Strategies for targeting and monitoring the impact of water supply. In villages of high and very high endemicity, providing a borehole or other safe water supply results in an immediate and precipitous decline in the number of

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dracunculiasis cases. In contrast, the impact of new water supply in villages of low and very low endemicity is minimal. Further evaluation of the impact of water supply is required so that more effective and cost-efficient targeting strategies can be developed.

VI. HEALTHY LIFE-STYLES FOR YOUTH

108. The JCHP stressed that there is a need for a holistic intersectoral approach in order to involve young people personally in the implementation and evaluation of all joint WHO/UNICEF efforts on their behalf. The importance of equity between the sexes in achieving the objectives set out in the document under review[22] was emphasized. The consequent need to strengthen the status of young women, in order to enable them to work together with young men towards the achievement of such equity, was noted.

109. The JCHP pointed to the importance of establishing healthy patterns of behaviour in childhood and adolescence to prevent both short- and long-term problems. To achieve major objectives it is important that all key groups that influence young people's behaviour or provide care need to be involved, including families, teachers, religious figures, health workers, and youth leaders. This will also ensure the cultural relevance of action taken. In reaching out-of-school youth, particularly, it should be remembered that they are comprised of many different groups, including those employed, those unemployed, those living in rural, urban and peri-urban areas, and younger and older adolescents.

110. The JCHP also noted that WHO and UNICEF share a strength that is rare, if not unique, in the United Nations system - that of being able to address issues relating to drugs, alcohol and tobacco directly through their substance abuse programmes. The JCHP encouraged UNICEF and WHO to consult further on the issue of abuse of illicit drugs and psychotropic substances, using as a guideline the Global Plan of Action on Substance Abuse, adopted by the Seventeenth Special Session of the United Nations General Assembly in 1990. However, UNICEF's experience in the area of substance abuse is limited as yet, and the two secretariats are actively discussing the form that their collaboration can most effectively take.

111. It was noted that controlling tobacco and substance abuse is of particular importance to healthy life-styles. The JCHP welcomed the cooperation between UNICEF and WHO especially with regard to the use of illicit drugs. Young people and children are the first to fall victim to such drugs. It is necessary, however, to distinguish between abuse of drugs and abuse of illicit substances, such as psychotropic drugs. In September 1990, a joint staff consultation was held between the secretariats of UNICEF and WHO and such consultations will continue. There was consensus that the two organizations should support countries in identifying national policies that will have an impact on young people's health and in identifying and sharing information on successful and reproducible programmes. They should help countries to develop public education programmes appropriate to specific cultural milieux. In this respect the joint publication of UNICEF, WHO and UNESCO, Facts for Life,[23] could be a useful tool.

112. The young people most at risk are those who are most difficult to reach through school programmes and youth organizations. Everyone has a high stake in finding ways of communicating effectively with young people and trying to persuade them to avoid or change their high-risk behaviour. The hope was expressed that the work would be accelerated and that the beginnings of a UNICEF programme of action could be reported to the Committee at its next regular session.

113. Three courses of action were emphasized. First, education for health in schools should be given top priority and should then be extended to out-of-school children. Nearly all countries now include education for health in their school curricula - a measure that is most cost-effective for immediate and long-term results with respect to behaviour change. Second, it is important to identify the most important messages to be

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[22] Document JCHP28/91/14.

[23] Available from UNICEF, New York.

conveyed to young people and to prepare educational workers and teachers for that purpose. The media should also be activated to disseminate that message. Third, youth organizations must be reached at all levels, in order to legitimize and provide social support for young people and build up pressure for health policies, legislation and fiscal support to promote healthy life-styles.

114. It was also emphasized that a healthy life-style is not purely physical in character but also involves mental and spiritual well-being. Broadly speaking, healthy life-styles also include responsible sexual behaviour leading to reproductive health, healthy eating, exercise, and oral hygiene as well as the avoidance of tobacco, alcohol and drug use.

115. The JCHP supported the recommendations contained in the document under review. The health of young people is an issue of priority concern to all societies because it involves the future of humanity. In order to achieve healthy life-styles, national authorities, including ministries of health, education and culture, need to create a coordinated intersectoral programme, which could be implemented in cooperation with UNICEF, WHO, UNESCO, UNFPA, and relevant nongovernmental organizations.

116. Recommendation[24]

The Committee recommends that WHO and UNICEF should support countries in:

(a) Developing public education programmes appropriate to the specific sociocultural milieu, to be directed through parents (to reach young children), through schools, youth and outreach organizations, society and the general public (towards older pre-adolescent children). Particular attention must be given to the needs of out-of-school youth.

(b) Promoting the incorporation of counselling skills and knowledge regarding healthy life-styles for youth in the initial and in-service training of professionals in the health, education, youth, social affairs, religious, and related sectors.

(c) Developing or strengthening the information systems required to monitor and direct interventions to reduce "high-risk" health and safety behaviour.

(d) Monitoring trends and patterns of sexual and reproductive health behaviour in young people in order to improve programme actions.

(e) Developing information dissemination and referral mechanisms to promote the use of available services.

(f) Identifying and advocating national policies and legislation that have an impact on young people's health.

(g) Identifying and sharing information about successful and replicatable programmes and projects that contribute to healthy life-styles among youth.

(h) Strengthening both global and country-level monitoring systems required to evaluate the effectiveness of these interventions.

VII. WOMEN, CHILDREN AND AIDS

117. The JCHP was informed that the AIDS pandemic continues to spread to more countries and has in no way reached its peak. Some 8-10 million adults are infected, but it is estimated that the figure will reach at least 20 million by the year 2000. A total of 700 000 children under the age of five are infected with human immunodeficiency virus (HIV), but as many as 10 million could be HIV-infected by the year 2000, most of whom

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[24] See also the recommendation concerning resolution WHA42.41 in paragraph 26(2).

will have AIDS because the period between infection and disease is much shorter in children. Africa has been most severely affected, with 30% HIV prevalence rates in many urban areas in East and Central Africa. By the year 2000 there may be at least 10 million "AIDS orphans" in sub-Saharan Africa. In Asia, markedly increasing rates of infection have been seen in the past year - for instance, in India, Myanmar and Thailand - especially in groups of female prostitutes and intravenous drug users, so that it is not surprising that infection is increasingly occurring in the general population as well. In the Caribbean, the highest rates of AIDS cases have been found in the Bahamas and Bermuda; in Latin America, there is an increasing problem especially in Brazil and Mexico. The key point is that HIV infection and AIDS are becoming a problem in developing countries; by the year 2000, at least 80% of cases will be in those countries.

118. The JCHP was further informed that HIV continues to be spread only through sexual intercourse, contaminated blood and perinatal infection, 80% of the infections being spread by sexual intercourse and primarily by heterosexual intercourse. HIV is therefore essentially a sexually transmitted disease. Of the remainder, 10% is spread through contaminated blood, including intravenous drug use, and 10% perinatally. It is now known how HIV infection through all those routes could be prevented. Sexual transmission could be prevented by promoting safer sexual practices and the use of condoms, and also by the treatment of sexually transmitted diseases, since persons with those diseases have a 5-10 times greater risk of transmission of HIV and of being infected with the virus. Blood-borne transmission could be prevented by screening blood and preventing intravenous drug use. Perinatal transmission, the main route of infection in children, could be prevented by preventing the infection of women. None of those interventions is easy, but all are feasible. An increasing number of examples of successful interventions has been seen in both developed and developing countries, especially with regard to increasing the use of condoms by young adults. In any event, even if attempts to change the sexual practices of adults are not fully successful, a significant impact on youth is possible through education programmes which would prevent infections in the next decade.

119. The priorities for the Global Programme on AIDS for the next few years are aimed at: strengthening national programmes; promoting a multisectoral response to dealing with the health, social and developmental aspects of the pandemic, including the care of orphans and making provision for the loss of a considerable proportion of the work force in some African countries; carrying out studies to improve the technical aspects of interventions; supporting research to test new vaccines and drugs; continuing efforts to prevent discrimination against HIV-infected people; and combating complacency, which is still present in some low-prevalence countries.

120. The JCHP noted that WHO has taken the leadership within the United Nations system in the global response to the AIDS pandemic, and that it encourages the full involvement of UNICEF in that effort and counts on and needs its support. UNICEF's expertise in social mobilization and communication should be invaluable in supporting national efforts in AIDS prevention. Unless effective AIDS control programmes can be mounted worldwide, it will be difficult if not impossible to achieve the goals that the World Summit for Children has set for women's and children's health, especially for maternal and child mortality.

121. The JCHP was informed that since 1988 UNICEF has supported activities of AIDS prevention programmes in many African countries and in the Caribbean and is beginning to do so in Thailand and other countries in South-East Asia. All these activities are closely coordinated with those of the Global Programme on AIDS. UNICEF is concerned mainly with three areas: the direct impact on women and children in terms of morbidity and mortality; the indirect impact on women and children, including socioeconomic effects such as the destabilization of families and the rapidly increasing number of "AIDS orphans"; and the complex interrelationship between AIDS-related illness in children and other child health problems. Its main input is in education programmes, including programmes for adults, through social mobilization channels, as well as the education of schoolchildren and out-of-school youth, including street children. UNICEF is supporting some governments in developing services for AIDS-affected women and their families and will continue to expand activities and assess their impact. UNICEF has also

offered its services for condom procurement. Discussions are under way to explore the potential of Bamako Initiative activities for distributing condoms and introducing AIDS prevention and control elements into community health schemes.

122. Action to improve the status of women is essential. This is a social issue with important health implications and cuts across nearly all aspects of activity in the health field. The 1990 World AIDS Day theme was "Women and AIDS".

123. The JCHP noted that the goals to be achieved by the Global Programme on AIDS by the year 2000 have not yet been set. It was explained that no decision has yet been taken on the goals for AIDS prevention owing to the very recent emergence of the disease and the lack of sufficient experience in dealing with it. However, it is hoped such goals can be established within the next year or two. Such indicators as the proportion of the population who know how HIV is transmitted, the percentage using condoms, and the prevalence of HIV infection in pregnant women or children under five are all under consideration. A report on the subject will be made to the next regular session of the JCHP and other United Nations agencies will be consulted before a final decision was made.

124. It was noted that in some countries, especially those with a low prevalence of AIDS cases, there is considerable complacency with regard to preventive action. However, the best time to take such action is before the prevalence rate has reached a level at which it becomes unmanageable. In some countries the complacency observed arises in part from the long period between infection and disease. The fact remains, nevertheless, that AIDS is a worldwide pandemic and calls for a global response. Although WHO action on AIDS is undertaken in collaboration with ministries of health, control of the disease is a multisectoral issue and efforts will have to be made in collaboration with UNICEF, UNDP, the World Bank and other organizations to interest other national ministries in action essential for AIDS control.

125. The JCHP recognized that promotion of safer sexual practices is not an easy task, as many factors affect behavioural change. Greater consideration needs to be given to such factors and to the best ways of inducing people to adopt responsible behaviour, of bringing home to them the reality of the risks they face and pose to others, and of convincing them of their own responsibility for action. Consideration has to be given to how to act on attitudes and perceptions to ensure that knowledge acquired is translated into behavioural change.

126. UNICEF had developed special expertise in areas such as social mobilization, culturally-sensitive health education, and an ability to work at community level that could make a significant contribution to combating AIDS. Community leaders, particularly in the spheres of religion and culture, will need to be involved in cultivating a receptive atmosphere, and WHO and UNICEF could jointly sponsor research on how to introduce changes in sexual behaviour.

127. The JCHP agreed that any enhancement of UNICEF's role in the fight against AIDS may be further considered by the UNICEF Executive Board.

128. Recommendations

(1) The JCHP recommends that in the pursuit of their collaborative and complementary activities, WHO and UNICEF should continue to ensure that their activities are consistent with existing strategies for health promotion and disease control. Among the areas to be explored for future collaboration and complementary action are:

(a) effective interventions for behavioural change (e.g., condom use) leading to the prevention of HIV transmission (general principle: promotion of healthy life-styles);

(b) early diagnosis and treatment of sexually transmitted diseases (general principle: early intervention);

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(c) integration of AIDS prevention and control activities into existing health programmes, including those for sexually transmitted diseases, maternal and child health, and family planning (general principle: programme integration);

(d) specific focus on women in all AIDS prevention and control programmes (general principles: recognition of the impact of women's lower status in the family and society on the health of women and their children; the health of women is closely related to their cultural, social and economic status; education of women will promote their advancement);

(e) social and behavioural research on the prevention of sexual transmission; biomedical research on potential vaccines and affordable drugs, making maximum use of national institutions (general principle: emphasis on research and development);

(f) further development of community-based projects with nongovernmental organizations active in HIV/AIDS control (general principle: support for NGO activities in prevention and health care).

(2) The JCHP also recommends that specific strategies in these and other areas be targeted both at persons with risk behaviour and at the general public, and tailored to the cultural specificities and sensitivities of the target populations.

VIII. MANAGEMENT OF THE PERIPHERAL HEALTH SYSTEM BASED ON PRIMARY HEALTH CARE

129. The Chairman recalled that, when adopting its agenda and plan of work, the Committee had agreed not to have the background paper formally introduced; it was nevertheless important to look at the issues and their implications for the planning and management of primary health care from the level of the community upwards to the health centre and district levels. These three levels, which constitute the district health system, represent the unit in which all efforts come together to create the desired impact. He therefore requested the opinions of the JCHP members to guide both secretariats in arriving at a consensus on how best to support countries to strengthen their health infrastructure.

130. The JCHP recognized the importance of the topic, which lies at the very heart of smooth and effective collaboration between UNICEF and WHO. UNICEF has focused on programme delivery at the community level, with special attention to child survival and development; support and supervision should be provided by the district. UNICEF's emphasis has been on strengthening the structures established for the achievement of universal child immunization in order to enable them to deliver other primary health care services. WHO's emphasis has been on development of comprehensive national health systems. As both approaches are intended eventually to reduce mortality, it should be possible for them both to be implemented. However, the modalities for doing so must be worked out. The methods by which programmes might be integrated into primary health care systems should be established. Governments have not been showing the same enthusiasm for primary health care as for other programmes that have been given special emphasis. WHO and UNICEF must therefore look into what is behind the apparent enthusiasm for EPI, AIDS control or oral rehydration therapy but not for primary health care. There are still two different notions concerning community health care: is it a "central" or a "peripheral" part of the health infrastructure? Concepts such as this need to be worked out and understood.

131. The principle of the primary health care strategy is that health begins at home. A referral health system is required, but the types of activities (roles) of various levels are different. For example, the problem of perinatal deaths can be tackled by strengthening the first referral level, whereas the prevention of neonatal deaths has to be solved at the grass-roots level. Thus the community is part of a district-based health care system and is therefore at the centre of the concerns of both organizations. A common strategy is required, with each organization maintaining its own specificity.

To provide a better understanding of a district health system, a short film is available from WHO.[25]

132. The JCHP considered that the modalities for cooperation should be further considered by the two secretariats and submitted as an item on the agenda of a special session of the JCHP in 1992.

133. Recommendations

(1) The JCHP recommends that WHO and UNICEF should continue to discuss the modalities for supporting countries in implementing primary health care based on health for all and within the structure of the national health system with a view to reaching consensus on joint activities.

(2) The JCHP also recommends that this should be one of the two main topics to be discussed at the recommended special meeting of the Committee in 1992.[26]

IX. PROGRESS REPORTS

Health economics

134. The progress report before the Committee[27] covered an area to which both Executive Boards have devoted considerable attention, particularly in view of the need to make maximum use of the scarce resources available for health.

135. WHO and UNICEF have worked closely together at country, regional and global levels. WHO's activities have focused on country-based support in the overall review of health policy in the light of a country's macroeconomic situation, together with the identification and appraisal of financing policy options; issue-based activities involving the analysis of a selected problem on the basis of experience in a group of countries, including work on recurrent costs, user fees, and health insurance; capacity building in economic and management skills, by means of short courses and training materials for senior and middle-level managers; and the production and sharing of information at global level on experiences and activities in health financing and economics, whether from countries or international agencies.

136. UNICEF will be expanding its health economics base with the establishment of a new Costs and Economics Unit within the Programme Division in New York. At the macroeconomic level, UNICEF has focused on global economic trends, "Adjustment with a Human Face", debt relief for children, allocation of donor resources for human development, and the cost of implementation of the goals for the 1990s endorsed by the World Summit for Children. At the microeconomic level, the Bamako Initiative and support to primary health care at the grass-roots level have also meant UNICEF's involvement in community financing, community management of funds, etc. The absence of an intermediate, or "mezzo", level has been felt, especially to work on options appraisal, and it is hoped to reinforce that aspect during 1991. In the 1990s a major challenge will be to determine the options available in order to reach the goals established at the World Summit. Health costing and financing aspects will therefore be particularly important and UNICEF will continue to work very closely with WHO.

The JCHP took note with satisfaction of the report.

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[25] "The district - A framework for health"; a WHO video cassette produced by Hourglass Pictures Limited, London, 1990.

[26] See paragraph 33(2).

[27] Document JCHP28/91/17.

Bamako Initiative

137. The document before the Committee[28] was an assessment by UNICEF of the progress made in the Bamako Initiative to date, both with continuing preparatory activities and with implementation in a core group of 12 countries. The JCHP noted that at the June 1990 Pan-African Conference on the Financing of Community Health Activities, organized by the WHO Regional Office for Africa in collaboration with UNICEF, the African countries renewed their commitment to implement the Initiative, in order to achieve the health goals of the 1990s. The Committee also noted that UNICEF and WHO continue to collaborate at country level, often through joint involvement in national task forces. The Bamako Initiative aims at increasing people's and governments' capacity to address their health situations, to better understand existing problems, and to improve the management of resources being used for health.

138. There is a growing consensus among international development agencies about the need to focus on the long-term health needs in Africa. The consolidation of existing efforts into coherent district-based health systems, with community involvement in their management and financing, is viewed as the way to establish services that could be sustained even in the most difficult economic, social and political circumstances. The increasing prominence of the World Bank in African health development has been especially noticeable in 1990, along with the growing presence of the European Community.

139. It was emphasized that governments have an important role to play in the procurement of drugs, financing and the availability of foreign currency, and the rational use of drugs. At the same time, economic and financial reasons alone are not enough to determine strategy. The next progress report to the JCHP should include references to the joint guidelines agreed at the time of the signature of the Bamako Initiative, together with an indication of the extent to which the guidelines have been followed. The guidelines include government decentralization, commitment, and community action supported by UNICEF and WHO. Moreover, responsibility for health care cannot be wholly delegated to the community; the government must continue its general, normative functions and finance the health care system. On the question of implementation and sustainability, WHO and UNICEF should prepare jointly an evaluation of the experience so far on which to build. Such issues as the impact of the Bamako Initiative on existing programmes such as CDD and ARI, payment and equity considerations, conversion of local currency into hard currency, ways of guaranteeing sustainability in drug supply, and quality control still need to be evaluated.

140. The JCHP stressed that a meeting of minds between UNICEF and WHO is essential. The Bamako Initiative differs from the essential drugs programme in that the latter takes a comprehensive approach to the accessibility of essential drugs and their rational use, including secondary and tertiary levels, whereas the Initiative is concerned mainly with the first level of primary health care. The two approaches could be complementary. In one country, for example, drugs are procured in several ways, including small local production by the government of essential drugs in support of primary health care. The Bamako Initiative is a simple programme which, if used properly, could enhance primary health care development, particularly at village level. Each country should work out its own basis for such things as purchase and quality control of drugs.

141. Extraordinary efforts will need to be made in the 1990s to build an effective primary health care system in Africa. The large number of low-income countries in the region suffer particular problems owing to such factors as low prices for their commodities, a heavy burden of external debt, and more recently the impact of AIDS. The goal of attaining health for all by the year 2000 through primary health care will be harder to attain in this region than elsewhere. Efforts should be stepped up on all possible fronts, including the Bamako Initiative.

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[28] Document JCHP28/91/18.

142. Recommendation. The JCHP noted with satisfaction the progress report on the Bamako Initiative contained in document JCHP28/91/18 and urges WHO and UNICEF to continue to strengthen their cooperation in revitalizing primary health care, paying attention to the appropriate health infrastructure needed to achieve the goals. In the light of this, the following should be considered: (a) in the short term, monitoring the implementation of the guiding principles of the Bamako Initiative within the national health system; (b) in the long term, assisting in establishing industrial factories or lines of production for primary health drugs as a way of ensuring sustainability and continuity.

Malaria control

143. The Committee noted with satisfaction the progress report on malaria control.[29] One important development since the twenty-seventh session of the Committee has been the increasing concern about the impact of malaria on health, in particular on the health of young children and pregnant women. UNICEF's interest in studying new approaches for malaria control was also welcomed by the Committee, which noted that the first joint discussions between the two secretariats had taken place three weeks earlier in New York, as part of increased contact relating to tropical disease control. There was a need for global commitment to current technical control strategies, and the WHO Executive Board had recommended in 1990 that WHO organize a world conference to obtain such commitment. UNICEF and WHO could present a joint declaration on such an occasion.

144. The control of malaria has moved from the eradication campaign approach of the late 1960s to a more locally adapted epidemiological approach. Few programmes have, however, successfully implemented this change in orientation, and much work is being undertaken to make the epidemiological approach more "user friendly". There are eight major patterns or paradigms of malaria: malaria of the African wet savannah, forest malaria, malaria associated with irrigated agriculture, highland fringe malaria, desert fringe and oasis malaria, urban malaria, plains malaria associated with traditional agriculture, and seashore malaria. Once the patterns are determined for a country, consideration is given to the principal determinants allowing the technical and sociological characteristics of the situation to be clearly described. The next step is to give consideration to the limited range of tools available for malaria control. This provides a framework for the analysis of malaria situations and the planning of appropriate and cost-effective interventions. The patterns furthermore provide a means of improving the quality of communication about malaria with nonspecialists, as well as a tool for training adaptable to all levels. It is hoped that the new approach will reattract financing agencies to support the malaria programme.

145. Finally it was noted with satisfaction that a WHO/UNICEF working group has been established to intensify efforts in the development of approaches to malaria control.

Onchocerciasis (river blindness): distribution of ivermectin

146. Onchocerciasis (or river blindness), like sleeping-sickness and dracunculiasis, is an "end of-the-road" disease, affecting the poorest of the poor. The areas most acutely affected are all the countries of sub-Saharan Africa, with more than 15 million people infected and 350 000 blind in consequence; and in Central America and northern South America some 55 000 people require treatment. A conference is to be held in Mexico and Guatemala in April 1991 to plan strategies for an anti-vector campaign with a view to eradicating onchocerciasis from the Region of the Americas.

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[29] Document JCHP28/91/19.

147. The JCHP was informed that, while there is no problem in issuing ivermectin to ministries of health and regional organizations, there is a bottle-neck in the delivery of the drug to the remote villages and hamlets, where it is most needed.

148. Certain nongovernmental organizations are helping with the effort through WHO's Programme for the Prevention of Blindness, and a meeting is to be held in April 1991 to contact those organizations and to target the populations to be treated.

149. UNICEF is collaborating with WHO in the distribution of ivermectin and will be intensifying its activities in this area over the next two years. Ivermectin is not generally given to children under five or to pregnant mothers, which leaves out of the picture a large section of those at risk. Nevertheless, the effect of ivermectin on the community will certainly affect the future of children, and UNICEF is therefore committed to supporting the programme.

The JCHP took note with satisfaction of the progress report.[30]

X. DATE OF NEXT SESSION OF THE JCHP

150. It was recommended that, with the consent of the Executive Boards of WHO and UNICEF, a special session of the UNICEF/WHO Joint Committee on Health Policy lasting one and a half days should be held in January 1992, the dates to be arranged between the two secretariats.

151. The date and place of the next regular session would be decided at the special session in January 1992.

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[30] Document JCHP28/91/20.

ANNEX 1

UNICEF-WHO JOINT COMMITTEE ON HEALTH POLICY
Twenty-eighth session
Geneva, 28-30 January 1991

AGENDA

1.	Opening	
	1.1 Statements by the Director-General of WHO and the Executive Director of UNICEF	
	1.2 Election of Chairman and Rapporteurs	
	1.3 Adoption of agenda	[JCHP28/91/1]
2.	Review of WHO health policies and UNICEF resolutions	[JCHP28/91/2]
3.	World Summit for Children	[JCHP28/91/3]
4.	WHO/UNICEF common goals for women and children - challenges for the 1990s	
	*4.1 Health and social basis of the common goals	[JCHP28/91/4]
	4.2 Reduction of infant and child mortality	[JCHP28/91/5]
	4.3 Women's health, safe motherhood and newborn care	[JCHP28/91/6 Rev.1]
	4.4 Promotive and preventive actions	
	4.4.1 Expanded Programme on Immunization	[JCHP28/91/7]
	4.4.2 Diarrhoeal diseases control	[JCHP28/91/8]
	4.4.3 Control of acute respiratory infections	[JCHP28/91/9]
	4.4.4 Nutrition	[JCHP28/91/10]
	4.4.5 Breast-feeding	[JCHP28/91/11]
	4.4.6 Water and sanitation	[JCHP28/91/12]
	4.4.7 Dracunculiasis (guinea-worm disease)	[JCHP28/91/13]
5.	Healthy life-styles for youth	[JCHP28/91/14]
6.	Women, children and AIDS	[JCHP28/91/15] [EB87/23]
7.	Management of the peripheral health system based on primary health care	**[JCHP28/91/16]
8.	Progress reports on specific topics	
	8.1 Health economics	[JCHP28/91/17]
	8.2 Bamako Initiative	[JCHP28/91/18]
	8.3 Malaria control	[JCHP28/91/19]
	8.4 River blindness (ivermectin distribution)	[JCHP28/91/20]
9.	Other matters	

* Item deleted.

** For background information only.

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ANNEX 2

UNICEF-WHO JOINT COMMITTEE ON HEALTH POLICY
Twenty-eighth session
Geneva, 28-30 January 1991

LIST OF PARTICIPANTS

UNICEF Executive Board members

Mrs Esther Ashton
Counsellor
Permanent Mission of Bolivia to the United Nations, New York

Mr Gabriel G. Fernandez
Chairman, Programme Committee
Counsellor
Permanent Mission of the Republic of Liberia to the United Nations, New York

Dr Audrey F. Manley, Rapporteur[1]
Deputy Assistant Secretary for Health
Department of Health and Human Services
United States of America

Mrs Elsie Mbella Ngomba
Second Counsellor
Permanent Mission of the Republic of Cameroon to the United Nations, New York

Mrs Lisbet Palme[2]
Chairperson, Executive Board
Sweden

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Executive Secretary
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[1] Assisted by Mrs Linda A. Vogel, Department of Health and Human Services, USA.

[2] Assisted by Ms Dorrit Alopaeus-Stahl, Ministry for Foreign Affairs, Sweden.

[3] Alernate member replacing Professor O.E. Hassan.

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Annex 2

UNICEF Secretariat

Mr James P. Grant, Executive Director
Dr R. Jolly, Deputy Executive Director
Dr Nyi Nyi, Director, Programme Division
Mrs M. Newman-Black, Office of the Secretary, Executive Board
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Dr J. Christmas, Coordinator, Water Supply and Sanitation Cluster
Mr J. Donahue, Director, Evaluation Office
Dr D. Fraser, Consultant
Dr J.P. Greaves, Senior Adviser, Micronutrients
Dr T. Hill, Senior Adviser, Health, and Chief, Child Survival Unit
Dr A. Paganini, Manager, Bamako Initiative Management Unit
Ms E. Preble, Senior Adviser, AIDS
Dr J. Sherry, Senior Officer, Programme Strategy
Dr S. Basta, Director, UNICEF Geneva

WHO Secretariat[1]

Dr Hiroshi Nakajima, Director-General
Dr M. Abdelmoumène, Deputy Director-General
Mr D.G. Aitken, Assistant Director-General (ADG)
Dr F. Antezana, Chief, Action Programme on Essential Drugs (DAP)
Dr J.E. Asvall, Regional Director for Europe (EURO)
Dr M. Belsey, Programme Manager, Maternal and Child Health (MCH)
Dr D.B. Bisht, Director, Programme Management, Regional Office for South-East Asia (SEARO)
Mrs I. Brüggemann, Representative of the Director-General of WHO to the United Nations System and other Intergovernmental Organizations, New York (DGR/LUN)
Dr E. Chigan, Director, Noncommunicable Diseases and Health Technology (NHT)
Dr C. Chollat-Traquet, Tobacco or Health (TOH)
Dr P. de Raadt, Associate Director, Control of Tropical Diseases (CTD)
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Dr E. Doberstyn, Chief, Malaria Control (MAL)
Dr J. Dunne, Director, Drug Management and Policies (DMP)
Mr H. Emblad, Director, Programme on Substance Abuse (PSA)
Dr H. Friedman, Chief, Adolescent Health (ADH)
Ms T. Gastaut, Programme Manager, Office of Information (INF)
Dr H.A. Gezairy, Regional Director for the Eastern Mediterranean (EMRO)
Dr E. Goon, Director, Development of Human Resources for Health (HRH)
Mr M. Grant, Programme on Substance Abuse (PSA)
Dr I. Gyarfas, Chief, Cardiovascular Diseases (CVD)
Mrs D. Halvorsen, Office of External Coordination (ECO)
Dr H.A. Hamad-Elneil, Director, Emergency Relief Operations (ERO)
Dr A. Hammad, Adviser on Health and Development Policies (DGO)
Dr S.T. Han, Regional Director for the Western Pacific (WPRO)
Dr H.R. Hapsara, Director, Epidemiological Surveillance and Health Situation and Trend Assessment (HST)
Dr R.H. Henderson, Assistant Director-General (ADG)
Dr S. Holck, Global Programme on AIDS (GPA)
Dr Hu Ching-Li, Assistant Director-General (ADG)
Dr J.-P. Jardel, Assistant Director-General (ADG)
Dr Y. Kawaguchi, Director, Planning, Coordination and Cooperation (PCO)
Dr R. Kim-Farley, Director, Expanded Programme on Immunization (EPI)
Dr U Ko Ko, Regional Director for South-East Asia (SEARO)

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[1] A number of the WHO technical staff on this list attended only for the discussions on specific agenda items.

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Annex 2

Dr W. Kreisel, Director, Environmental Health (EHE)
Dr R.F.M. Le Berre, Chief, Filariasis Control (FIL)
Dr Liu Guo-bin, Director, Programme Management, Regional Office for the Western Pacific (WPRO)
Dr Maaza Bekele, Office of External Coordination (ECO), Secretary
Dr C. Guerra de Macedo, Regional Director for the Americas (AMRO)
Dr J. Martin, Office of International Cooperation (ICO)
Dr J.R. Menchaca, Programme Manager, Tobacco or Health (TOH)
Dr M. Merson, Director, Global Programme on AIDS (GPA)
Dr G.L. Monekosso, Regional Director for Africa (AFRO)
Dr J.A. Najera-Morrondo, Director, Control of Tropical Diseases (CTD)
Dr N.P. Napalkov, Assistant Director-General (ADG)
Dr W.C. Newbrander, National Health Systems and Policies (NHP)
Dr S. Ngalle Edimo, Management Health System, Regional Office for Africa (AFRO)
Dr J.H. Orley, Mental Health (MNH)
Dr A. Petros-Barvazian, Director, Family Health (FHE)
Dr A. Pio, Programme Manager, Control of Acute Respiratory Infections (ARI)
Dr A. Pradilla, Programme Manager, Food and Nutrition Programme (FNP)
Professor V. Ramalingaswami, Special Adviser to the Director-General (DGO)
Dr P.J.A. Ranque, Filariasis Control (FIL)
Dr D.K. Ray, Chief, Governing Bodies and Protocol (GBP)
Dr J. Rochon, Director, Health Protection and Promotion (HPP)
Dr M. Sathianathan, WHO Senior Health Adviser to UNICEF, New York (WAU)
Mr H. Sato, Adviser on Policy Cooperation (DGO)
Dr E. Tarimo, Director, Strengthening of Health Services (SHS)
Dr Aseffa Tekle, Adviser on Programme Promotion and Integration (DGO)
Dr G. Torrigiani, Director, Communicable Diseases (CDS)
Dr J.L. Tulloch, Director, Diarrhoeal and Acute Respiratory Disease Control (CDR)
Dr D. Warner, Manager, Community Water Supply and Sanitation (CWS)